Infusion Care, LLC - Patient Infusion Referral Form

Fax Completed form to (775) 409-4732

Patient Name: Date of Birth:

SSN: Primary Phone:

Address: Secondary Phone:

Insurance Provider

(PLEASE ATTACH LAST CHART NOTE) **(PLEASE ATTACH COPY OF INSURANCE)**

Diagnosis: ICD IO Code (s):

Section 1- Clinical *(Must be completed to initiate services with Vegas Valley Infusion Centers, LLC and facilitate insurance authorization.)*

NKDA Allergies:

Height: cm/inches Weight: kg/lbs Male Female

This is the first dose Yes No If No, list product:

Last infusion date: / / Next dose due: / / (IF APPLICABLE or KNOWN)

Line Type: PIV PICC Port Other

Section 2- Medication

Medication:	**Dose:**
Directions: **Infuse IV per manufacturer Guidelines** **Other:**	**Quantity/Refills:** **Dispense 1-month supply on all selected medications** **Refill 12 months unless otherwise noted** **Other:**

Section 3 - Premedication

RN to start peripheral IV or use existing CVC

Pre-medication will be given 30 minutes prior to infusion *(Medications will not be administered unless checked.)*

Diphenhydramine:	25 / 50 mg PO	**OR**	50 mg IV diluted in D5W, or NS 50-100 mL infused over 15 minutes
Antihistamine:	Loratadine 10 mg PO	**OR**	Cetirizine 10 mg PO
Solu-medrol:	125 mg IV push over 5 minutes	**OR**	mg slow IV push over 5 minutes
Acetaminophen:	325 – 650 mg PO	**OR**	mg PO
Famotidine (Pepcid):	mg slow IV push over 2 minutes		
Other Medication:			

Section 4 – Reaction Medications

(Medications only to be dispensed during adverse reaction event. These orders will be followed, and physician will be notified immediately)

Discontinue Infusion. Infuse D5W or NS at 20 mL/hour KVO. May increase to 100-250 mL/hour for hydration

Follow Infusion Care Facility Adverse Reaction Protocol, copy of same available upon request.

RN may administer the following if discontinuing infusion does not resolve symptoms:

Diphenhydramine 50 mg IV diluted in D5W or NS 50-100 mL over 15 minutes **OR** 50 mg / 10 mL NS IV push over 3 minutes, as tolerated.

Methylprednisolone 125 mg **OR** mg slow IV push over 5 minutes.

Acetaminophen 325-650 mg PO **OR** mg PO at onset of symptoms.

Ondansetron 4 mg slow IV push over 5 minutes **OR** 4 mg ODT.

Epinephrine (EpiPen Auto-Injector) as directed by patient weight per IM or SQ route during anaphylactic reaction. May repeat once.

(911 emergency medical services will be contacted if utilized)

Section 5 – Provider Information

Referring Physician Phone: Fax:

Address City State NV

License Number: DEA Number: NPI Number:

Physician Signature Date: